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Cherchez les Femmes

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Cover story: With the impact of the landmark nomination of a woman for vice-president and the impact of the much discussed gender gap eluding political observers, this is truly an election year in which to *"look for the women."* The significance for nursing becomes evident when one considers that one in 44 registered women voters who is a nurse. This month's "Washington Focus," on pages 370 and 371, examines the parties' records and the candidates' stands, paying special attention to health care issues.

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Graduate Education in Gerontological Nursing Revisited

H. TERRI BROWER

Graduate education assists in defining the scope and nature of nursing specialties. The need for a gerontological nursing major existed long before its development in the late 1970s. Although the first program was initiated in 1966, the real thrust came later.

Background

An initial study in 1976 of graduate programs in gerontological nursing indicated that there was wide variety in the eight functioning graduate programs, as well as indications of a lack of faculty expertise or a lack of emphasis on the major in some programs. Enrollment at that time, while small at an average of 10 students, was attributed to factors due to the novelty of the major, negative attitudes that nurses hold toward the aged, marketability of graduates, and the presence or absence of a visible gerontological focus in the larger university [*1*].

In 1980, the American Association of Colleges of Nursing identified 18 graduate programs in gerontological nursing that were accredited. Although no figures were provided on graduates or student enrollment in the programs, its prepared statement to a House of Representatives' subcommittee said: "they are reported to be attracting more students than the older, more traditional, majors" [*2*].

The number of programs had increased substantially, as reported by the Department of Health and Human Services, Division of Nursing. In 1981, the Division noted that 47 of some 70 federally supported advanced nurse training programs and nurse practitioner training programs "had substantive geriatric content" [*3*]. However, only 23 programs were considered to be addressing the broad social issues of gerontology. The Division also noted that the government does not "pass on quality issues" related to curriculum content or on major or minor status.

Aspects considered essential by many gerontological leaders for a program in gerontological nursing include curriculum organization and content, presence of active research on aging, and faculty expertise [*4–6*]. In addition, there are quantitative aspects that concern numbers of students, programs, and graduates.

The nature of gerontological nursing requires a multidisciplinary focus in order to prepare leaders who will have a broad theoretical framework. This requires the availability of courses on aging, as well as aging activities and research in the larger universities. Through the use of electives or cognates, students should be able to take courses in aging taught by departments other than nursing. While many universities have undergraduate gerontological courses, very few courses exist at the graduate level, and those that have graduate courses often have limited offerings.

Curriculum content within the nursing major should reveal the ability of the program to prepare future leaders in gerontological nursing. The long-term health care sector is perhaps the one in most dire need of leadership to create positive change. The extent of this need is illustrated by numerous statistical reports. The population that resides in nursing homes is comprised of more women and of increasingly sicker, and older, people, with 95 percent now requiring some help with activities of daily living [*7*]. It is appropriate to identify how graduate programs are responding to the challenge of this problem. Additionally, there are several important works that can serve to provide direction for designing graduate gerontological nursing curriculums.

Gunter and Estes have developed a comprehensive curriculum guide that covers content from the level of the nursing assistant to the doctorally

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*Table 1. Quality Indicators in the Curriculum of Gerontological Nursing Majors.**

	Schools Requiring 24–36 Credits to Complete MSN		Schools Requiring 37–60 Credits to Complete MSN		Schools Offering a Minor	
	No.	%	No.	%	No.	%
Require gerontology cognates	3	38	5	29	6	50
Permit electives	7	88	15	88	12	100
Require a long-term care course	2	25	5	29	5	42
Provide advanced assessment skills	6	75	15	88	10	83
Total schools	8 schools		17 schools		12 schools	

*Calculated only for schools supplying adequate information.

prepared nurse [*8*]. Their text includes level objectives and offers philosophical background and practical suggestions for faculty. Another work, although directed specifically at the baccalaureate level, is a critical one to review when designing graduate curriculums. Developed as a result of a joint Delphi research project, both content topics and nursing skills were identified. The study was performed jointly by the Gerontological Society of America and the American Association of Gerontology in Higher Education, although few nurses were invited to participate in the study [*9*]. Additionally, Brower has developed a conceptual framework with sample content considerations that can be helpful to both undergraduate and graduate curriculum designers [*10*].

The Survey

In order to determine the current state of a graduate program in gerontological nursing, a survey was conducted in the spring of 1982. Questionnaires were sent to all of those programs identified as having a major, subspecialty, or track in gerontological nursing [*1*]. Questionnaires were also sent to programs identified by DHHS's Division of Nursing's Nurse Practitioner Program and Advanced Nurse Training sections, and to others known to the author. Fifty-one questionnaires were distributed.

Responses

There were 47 respondents, for a response rate of 92 percent. Twenty-eight programs had a functioning major in gerontological nursing, and 7 were in planning stages, of which 2 identified that they were going to offer a major. (Not queried were 2 other programs that were planning the major, raising the total to over 32 identified as offering the major as of fall, 1983.) Seventeen respondents were offering a minor, and 5 offered both the major and minor. Two programs previously offering a major no longer offered it, of which one of these was dropped to a minor. Another program had a hiatus during which the gerontological major was not offered for two years due to the vacancy left by the key faculty person. Included now are 2 programs focusing on geropsychiatry, one offering a major, and the other, a minor.

In an effort to determine the nature of curriculums taught for the gerontological major, questions were asked concerning total number of credits, core nursing credits, gerontological cognates, presence of electives, existence of advanced assessments skills, and whether a long-term care course was taught. Some respondents did not answer all of the questions, and computations are based on those who did respond. The total number of credits in order to complete the MSN ranged from 24 to 60 credits; all credits were converted to semester hours.

Ten schools reported requiring between 24 and 36 hours, and 25 reported requiring 37 to 60 hours for completion of the degree (see Table 1). Schools requiring a greater number of credits tended to have a course in long-term care and to offer assessment skills, cognates, and electives, whereas schools having 36 or fewer credits tended to offer less.

Data were computed to ascertain the strength of the major by subtracting the number of core nursing credits, cognate credits, and elective credits. The amount of credits available for the major indicate the percentage of time that the student will be able to focus on the nursing major, which would be strengthened by the presence of gerontological cognates and/or electives. Credits available to focus on the major ranged from a low of 5 to a high of 45 nursing credits. Six programs had 16 or fewer credits in the major and, of these, three required cognates, indicating that the three remaining programs offering the major have exceptionally limited time allocated to the specialty. Seven programs had 18 to 25 credits in the major, with two of these requiring cognates. Only four programs had 27 to 45 credits in the major, with *none* of these offering cognates in gerontology. Extremes were reflected in two programs showing 45 credits and 5 credits, respectively, in the major. Both of these offer no cognates, one elective, and no course in long-term care, reflecting a limited focus in the major despite wide disparity in terms of required credit load.

In order to determine whether students were having difficulty attending school in light of reductions in traineeship monies, an effort was made to determine those students who were employed full time. There were no questions regarding part-time employment. Seven schools reported no enrolled students employed full time. Five reported between 10 and 49 percent working, four reported between 50 and 75 percent working, and three had between 80 and 100 percent of students working full time. One school reported 100 percent of students working, with none being able to maintain full-time study and full-time work combined. Table 2 shows the number of private and state schools reporting the percentage of

students on traineeships and the percentage working full-time (not all schools identified themselves in this category, and these were not included in certain comparisons). The availability of traineeships and whether the school was state or private had an effect on whether students worked full-time, with more private school students working whether or not they were able to obtain some traineeship support.

Student enrollment was analyzed in a number of ways. Full-time and part-time students were determined according to regions. Notably, no program having a major was found in the Mid-Central or Midwest regions (see Table 3). Using Chi Square statistics, there was a significant relationship ($<.0005$ level) between part-time and full-time enrollments and region. The Western region had more enrolled full-time students than expected, with 49 enrolled compared to the expected 32.1. The North-Central had fewer students enrolled (14) than the expected (39.1). Likewise, it can be seen that, in these two regions, the West had fewer part-time students, while the North-Central had far greater numbers of part-time students enrolled than expected. The Northeast had the greatest number of full-time students (one school from the Northeast, reporting only two students, was not included in the data analysis due to lateness of response), while the North-Central reported the smallest percentage of full-time students.

The effects of funding on student enrollment were analyzed for all schools, comparing those programs having no funds, those with five or fewer years of funding, and those with more than five years of funding (see Table 4). As can be seen, funding has a very significant effect on student enrollment. One nonfunded program, the first in the nation, had been in operation for 16 years, yet had only seven full-time students, while another nonfunded program, in operation for nine years, had only two full-time students. Six schools in operation six or more years reported having seven or fewer students enrolled full-time in the gerontological major.

Of all the programs offering the major, only four were not experiencing recruitment difficulties. Two of these four respondents qualified their status with such statements as, "We work at it all the time," and, "We have constant recruitment efforts; we expect difficulties in the near future." The rest of the respondents, *all* of whom identified difficulty with recruitment, were asked to speculate on the future of the major at their school. Ten responded that there was a commitment to continue, six responded that they were studying the issue or were unsure, and six said that the future of the major was limited or doomed. Word of mouth was noted to be the most significant recruitment measure, with brochures and public announcements adding additional help.

Table 2. Relationship of Student Employment to Traineeship Support.

State			Private		
No. of Schools	% Working Full-Time	% on some Traineeship Support	No. of Schools	% Working Full-Time	% on some Traineeship Support
3	0	100	1	10	100
1	0	50	1	0	75
			1	0	0
1	50	NA	1	10	100
1	50	50	1	10	90
1	80	NA	1	25	75
			2	100	100
			1	100	25
Totals: 7 schools			9 schools		

Table 3. Regional Distribution of Full- and Part-Time Students.

Full-time students	South	Northeast	West	North Central
Actual	34	55	49	14
Expected	34.7	49.1	32.1	39.1
Part-time students				
Actual	21	23	2	48
Expected	20.4	28.9	18.9	22.9
$X^2 = 69.55$	$p < 0.005$		df = 3	N = 254

Table 4. Student Enrollment for State and Private Institutions.*

Private	South	North East	West	North Central
Actual	20	25	0	12
Expected	14.8	19.4	17.2	5.6
State				
Actual	22	30	49	4
Expected	27.2	35.7	31.8	10.4
$X^2 = 74.6$	$p < 0.005$		df = 3	N = 162

Major Concerns

In addition to being plagued by small numbers of students and recruitment difficulties, respondents were queried as to their specific concerns for gerontological nursing. The primary concerns most frequently cited by 11 respondents were: a) motivating and stimulating interest in the major; b) the viability of the major as the priority concern; and c) position opportunities for graduates and salary compensation commensurate with qualifications and preparation. The second-most-voiced concern of eight

respondents was the difficulty of securing doctorally-prepared faculty with expertise in gerontological nursing. Four respondents saw the lack of scholarships or traineeships as a deterrent to programmatic development, whereas three cited inadequate undergraduate preparation as a problem.

Quality of applicants was also addressed. One respondent noted that three of the five applicants admitted to the major for the 1982–83 year were admitted on probation because of inability to meet entrance qualifications and further stated that other majors were rarely in a position in which they had to lower their admission qualifications. Two respondents voiced concerns that the program lacked sufficient depth and that the quality of the curriculum suffered, and several noted that assessment skills were not sufficiently applied. One was concerned over the lack of a long-term (secondary health care) focus in the program. One noted that national acceptance by nursing deans of gerontological nursing as a bona fide specialty was essential for success.

Discussion and Implications

This review suggests that the total number of credits available for the major is no indication of whether other qualitative aspects, such as cognates and a course in long-term care, are included. The dearth of courses in long-term care in programs espousing to teach the major is disturbing. By neglecting to include a long-term care focus, graduate gerontological educators may be unwittingly perpetuating the myth that there is nothing to learn in the nursing home setting. However, since graduates will be called on to consult or teach staff in nursing homes and, in some instances, to work in nursing homes, such an immensely critical component of care should be included.

There are several points to consider when discussing disparities: A number of programs are being initiated where there are none-to-limited numbers of graduate-level courses in gerontology available in the larger university. In some programs, other constraints are present, such as the increased movement toward core nursing curriculum, thereby weakening the specialty. Some programs have been planned and started by those who have little expertise or academic preparation in gerontological nursing.

The timing of the onset of the major is a critical determinant in the evolving specialty in gerontological nursing. Furthermore, because the need was so pressing, the major was initiated before adequate content in gerontological nursing had been integrated into undergraduate curricula. The major was initiated in many schools prior to the availability of gerontological nursing texts. Additionally, research in gerontological nursing has been limited, resulting in poorly identified content or content that lacked a firm grounding in nursing science. Therefore, an add-on approach to content by faculty lacking knowledge may have occurred in a number of programs. While there will continue to be content overlap between educational levels, the reluctance of undergraduate faculty to include gerontological nursing content continues to compound this problem.

Curriculum content within the nursing major should reveal the ability of the program to prepare future leaders in gerontological nursing.

Recruitment problems have resulted in many programs offering a minor instead of a major. But a minor is not a strong-enough focus to prepare the type of practitioners needed for education and practice. However, those who have had the opportunity to study in the minor may have had their appetites whetted sufficiently to choose a doctoral focus in gerontological nursing if they return to advanced study. Programs offering both the major and minor are needed. Schools that have sufficiently flexible curricular structures already offering the major should consider the addition of minors. Those programs that have achieved considerable success in the minor should plan expansion into offering the major, as well.

The defensive stance, as evidenced by denial of problems and inflated student enrollment by 10 respondents, does not allow clear identification of the problems. Unless faculty keep the problems in focus, there will be less done to identify solutions and strategies for alleviating recruitment problems. Leaders need to consolidate activities in order to enhance recruitment. A case can be made for legislation to prioritize traineeships for students to study in the specialty. Such initiatives could do a great deal toward overcoming the reluctance of nurses to study in the major.

It is interesting to note that advanced nurse traineeship monies were prioritized for nurse midwifery students in the Omnibus Reconciliation Act of 1981. The DHHS Division of Nursing interpreted this rule by giving increased amounts of traineeships to schools having midwifery programs. But some schools of nursing having both gerontological nursing and midwifery students further interpreted the rule to prioritize award monies to midwifery students. Nurse midwifery programs have no difficulty in obtaining students; instead, they have a two- to three-year waiting list and three to five applicants or more for each student admitted. This highly-sought-after major also has activist faculty and practitioners who are effective in lobbying for their cause.

Unfortunately, dwindling traineeship monies in most schools no longer cover even tuition costs, as they are divided up among eligible applicants. Private schools, because of high tuition, and the depressed North-Central region seem to have the most difficulty with students working full-time. Although two private schools indicated that 100 percent of their students received some traineeship monies, 100 percent of their students also worked full-time. Full-time employment while attending school full-time severely compromises learning ability. There is greater available traineeship support for the geropsychiatry majors, yet there were only one major (now there are two) and one minor identified with this focus. Additionally, the Veterans Administration has recently allocated a small amount of money to be used for a limited number of graduate nurse traineeships. However, in spite of the reality that the VA health care system in-

creasingly faces the problems of caring for an aging veteran group, there was no attempt to make traineeships for graduate gerontological nursing study a priority.

The source of funding for programs can contribute to programmatic problems. Funded faculty lines from the Division of Nursing's Nurse Practitioner Section are permitted to teach only the specific content related to practitioner preparation and the major. When student enrollment was small, pressures on faculty to teach in other courses caused problems for faculty and project directors and resulted in reduced funding because of the small student numbers. This can result in demoralization and loss of key faculty persons. Furthermore, nurse practitioner funding rules and regulations were originally promulgated with continuing education programs in mind. A change in nurse practitioner funding regulation is indicated to more appropriately reflect the reality of part-time graduate student enrollment, since an increasing number of graduate gerontological programs is funded through this source and is unable to meet the current unrealistic student enrollment figures.

How long should programs receive federal funding to the exclusion of developing other programs? Four programs have received federal funds for 7, 8, 9, and 10 consecutive years. However, only two of these programs, both state schools, can be considered to have good student enrollment (the 9- and 10-year funded programs). The remaining two schools were private and continue to have low student enrollment. Whether or not programs are able to increase enrollment after five years of continuation of funding should be questioned by legislators, in view of tightening fiscal controls.

Although the lack of undergraduate preparation in gerontological nursing accounts for some of the recruitment difficulties, other factors can also be attributed. Nurses' attitudes toward aging, especially a number of those who work with the elderly have been found to be less than positive [*12–14*]. Turning around ageism is a monumental task that can only be affected by the constant sensitization of those harboring such views. Although increasing numbers of nursing leaders acknowledge the need for gerontological nursing education, both graduate and undergraduate, this has not resulted in adequate inclusion of such content in nursing programs. Greater nursing leadership in both the service and academic sectors is required to combat this problem.

Graduates of the new programs will be expected to assist in creating positive change. Gerontological nursing clinical specialists, role models in the service areas, can assist nurses by correcting stereotypes and by increasing knowledge in gerontological nursing. The clinical specialist is capable of consulting with others about the care, as well as demonstrating expert care, of the aged. The specialist can plan appropriate educational programs about aging on an ongoing basis for both staff and significant others. Service leaders can provide incentives for nurses to choose study in the field. They could begin by providing salary initiatives, offering a differential higher than those provided for specialties for which more clinical specialists are available.

Turning around ageism is a monumental task that can only be affected by the constant sensitization of those harboring such views.

Graduate gerontological nursing programs will continue to expand. Planners of such programs are encouraged to examine all of the variables that go into creating a superb offering. Recruitment and feasibility studies for interest in gerontological nursing, and position availability upon graduation, can greatly refine the planning process. Dean Valerie Prock has said that in order to produce viable leadership and programmatic development, a school should possess at least three faculty members who have expertise in gerontological nursing [*15*]. This is salient advice for planners.

References

1. Brower, H. T. "A Study of Graduate Programs in Gerontological Nursing." *Journal of Gerontological Nursing*, 3: 40–46, 1977.
2. Subcommittee on Health and Long-Term Care of the Select Committee on Aging, House of Representatives. "Prepared Statement of the American Association of Colleges of Nursing," in *Nurse Shortage and Its Impact on Care for the Elderly*. Washington, D.C.: U.S. Government Printing Office, 1981, p. 91.
3. U.S. Senate Special Committee on Aging. *Volume I: Developments in Aging: 1981*. Washington D.C.: U.S. Government Printing Office, 1982, p. 342.
4. Gunter, L. M., and Miller, J. C. "Toward a Nursing Research Gerontology." *Nursing Research*, 26: 208–224, 1977.
5. Brower, H. T. "A Study of Content Needs in Graduate Gerontological Nursing Curriculum." *Journal of Gerontological Nursing*, 5: 21:28, 1979.
6. Gunter, L. M., and Estes, C. A. *Education for Gerontic Nursing*. New York: Springer Publishing Co., 1979.
7. U.S. Senate Special Committee on Aging, 1981.
8. Gunter and Estes, 1979.
9. Johnson, R. H., Britton, J. H., Lang, C. A., *et al.* "Foundations for Gerontological Education, Part II." *The Gerontologist*, Special Issue, 20: 1–16 1980.
10. Brower, H. T., "The Nursing Curriculum for Long-Term Institutional Care," in *Creating a Career Choice for Nurses in Long-Term Care*. New York, N.Y.: National League for Nursing, 1983.
11. Council of Baccalaureate and Higher Degree Programs, *Masters Education in Nursing: Route to Opportunities in Contemporary Nursing in 1981–1982*. New York, N.Y.: National League for Nursing, 1981.
12. Brower, H. T., "Social Organization and Nurses Attitudes Toward Older Persons." *Journal of Gerontological Nursing*, 7: 293–298, May 1981.
13. Campbell, M. E., "Study of Attitudes of Nursing Personnel Toward the Geriatric Patients." *Nursing Research*, 20: 147–151, 1971.
14. Hart, L., Freel, M. I., and Crowell, C. M., "Changing Attitudes Toward the Aged and Interest in Caring for the Aged." *Journal of Gerontological Nursing*, 2: 10–16, 1976.
15. Prock, V., "One Dean's View," presentation given at the "Think Tank" conference on Attracting Nurses to Long-Term Care Settings Through Optimal Educational Experiences, San Diego, California, 1982.